Agency:	**107 Health Care Authority**
Decision Package Code/Title:	**ML2-BD Fund ProviderOne Enhancements**
Budget Period:	**2015-17 Biennial Submittal**
Budget Level:	**ML2 – Maintenance Level 2**

Recommendation Summary Text

The Health Care Authority (HCA) requests $2,350,000 ($235,000 GF-State) in the 2015-17 biennium to complete ProviderOne system enhancements that comply with federal regulations and enhance the effectiveness and utility of the system.

Package Description

ProviderOne is the state's Medicaid Management Information System (MMIS). It is a mission critical state system, paying healthcare providers and managed care organizations over $6 billion per year. The HCA requests funding to support two federally required enhancements and one enhancement that supports ongoing agency and provider end user business needs.

- Federal Requirement: The Committee on Operating Rules for Information Exchange (CORE) has established Operating Rules that facilitate administrative interoperability between providers and payers. ProviderOne is compliant with the CORE Operating Rules Phase I, II and III (compliance dates in January 2013 and January 2014). The new Operating Rules, called Phase IV have a compliance date of January 2016. Operating Rules Phase IV includes enhancements to the HIPAA 837 Claims, 834 Benefit Enrollment, 820 Premium Payment, and 278 Authorization transactions. The CORE Operating Rules build on existing HIPAA standards with the goal of further streamlining and increased efficiencies in the exchange of healthcare claims data.

- Federal Requirement: the HCA must enumerate for a National Health Plan ID (HPID) by November 5, 2014 and must use the HPID on HIPAA transactions by November 2016. In addition, ProviderOne must be modified to support use of the HPID by our Managed Care Organizations, Regional Support Networks and other impacted providers. This includes analyses and modifications of all inbound and outbound HIPAA transactions with these entities.

- Business Enhancement: ProviderOne was implemented using the CNSI core application referred to as eCAMS 1.0 User interface (UI). Since Washington's implementation, CNSI has upgraded their core product and they are now operating in other states on eCAMS 3.0 UI. An upgrade of ProviderOne to the eCAMS 3.0 UI would provide multiple benefits to ProviderOne end users. The changes reflect end-user feedback and provide new capabilities to support advancements in end-user browser technologies. The primary benefits include cross browser capability, enhanced/strengthened capabilities that improve security across the Medicaid enterprise and a variety of end-user benefits including intelligent "Quick Find" features, hot keys to increase productivity and expanded capability that enables end users to personalize their own system experience.

An enhanced match rate of 90 percent federal financial participation (FFP) is anticipated for each of these enhancements.

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Questions related to this request should be directed to Nicholas Aaseby at (360) 725-0455 or at Nicholas.Aaseby@hca.wa.gov.

Fiscal Detail/Objects of Expenditure

	FY 2016	FY 2017	Total
1. Operating Expenditures:			
Fund 001-1 GF-State	$ 200,000	$ 35,000	$ 235,000
Fund 001-C GF-Federal Medicaid Title XIX	$ 1,800,000	$ 315,000	$ 2,115,000
Total	**$ 2,000,000**	**$ 350,000**	**$ 2,350,000**

	FY 2016	FY 2017	Total
2. Staffing:			
Total FTEs	-	-	-

	FY 2016	FY 2017	Total
3. Objects of Expenditure:			
A - Salaries And Wages	$ -	$ -	$ -
B - Employee Benefits	$ -	$ -	$ -
C - Personal Service Contracts	$ -	$ -	$ -
E - Goods And Services	$ 2,000,000	$ 350,000	$ 2,350,000
G - Travel	$ -	$ -	$ -
J - Capital Outlays	$ -	$ -	$ -
N - Grants, Benefits & Client Services	$ -	$ -	$ -
Other (specify) -	$ -	$ -	$ -
Total	**$ 2,000,000**	**$ 350,000**	**$ 2,350,000**

	FY 2016	FY 2017	Total
4. Revenue:			
Fund 001-C GF-Federal Medicaid Title XIX	$ 1,800,000	$ 315,000	$ 2,115,000
Total	**$ 1,800,000**	**$ 315,000**	**$ 2,115,000**

Narrative Justification and Impact Statement

What specific performance outcomes does the agency expect?

This proposal is essential to achieving compliance with federal regulations. This request funds necessary work for the HCA to implement both the CORE Operating Rule Phase 4, HPID, comply with federal regulations and maintain FFP for Medicaid programs.

In addition, this proposal is essential in the upgrade of the ProviderOne system. The upgrade will continue to make ProviderOne a state of the art MMIS, improve and strengthen security capabilities

across the Medicaid enterprise, allow cross browser technologies to remain consistent with current technologies and offer "Quick Find" features including hot keys to increase staff productivity.

Performance Measure Detail
Activity Inventory
H003 HCA Information Technology

Is this decision package essential to implement a strategy identified in the agency's strategic plan?
The mission of the HCA is to provide high quality health care for the state's most vulnerable residents. This request funds necessary compliance activities that will ensure the viability of the Medicaid program.

Does this decision package provide essential support to one or more of the Governor's Results Washington priorities?
This proposal is essential to achieving the Governor's health care reform goals of controlling expenditures, creating more transparency in the health system and making better use of information technology. ProviderOne currently uses industry standard tools and architecture such as business rules engine, and best of breed commercial off the shelf (COTS) products while complying with federal regulations such at 42 CFR Part 455 subpart E. The design, development and implementation of the CORE Operating Rules Phase 4, HPID and ProviderOne upgrade ensures alignment with industry standards including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and HIPAA transaction standards.

What are the other important connections or impacts related to this proposal?
There will be significant stakeholder impact with the implementation of the CORE Operating Rules Phase 4, HPID, and ProviderOne upgrade to eCAMS 3.0. The impacts on health care clearinghouses, providers, including doctors, hospitals, tribal clinics, and long-term care facilities, can be positive if all these activities are adequately funded and well managed. The cross browser capabilities included in the eCAMS upgrade will introduce opportunities for the use of mobile services for providers.

What alternatives were explored by the agency, and why was this alternative chosen?
The HCA has only looked at implementing the CORE Operating Rules Phase IV, HPID, and ProviderOne upgrade to eCAMS 3.0. Other alternatives to the CORE Operating Rules Phase IV and HPID would not be considered HIPAA compliant and could result in severe financial penalties. The penalty for HIPAA non-compliance could be as high as $1.5 million per year per entity. In addition, there is a fee of $1 per day (not to exceed $7,040 per year) associated for not completing the CORE certification. In order for the HCA to continue to maintain a state of the art MMIS, the HCA must upgrade the ProviderOne system from eCAMS 1.0 to eCAMS 3.0.

What are the consequences of adopting this package?
Funding is necessary to assist the HCA to implement the CORE Operating Rule Phase 4, and HPID. Doing so allows the HCA to comply with federal regulations, and avoid financial penalties.

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What is the relationship, if any, to the state capital budget?
None

What changes would be required to existing statutes, rules, or contracts, in to implement the change?
A Change Order and resulting amendment to the ProviderOne contract with Client Network Services Incorporated (CNSI) will be required for the system enhancements.

Expenditure and Revenue Calculations and Assumptions

Revenue Calculations and Assumptions:
Revenue assumes that all three projects will qualify for 90 percent FFP for Design, Development and Implementation (DDI).

Expenditure Calculations and Assumptions:
The HCA plans to only use existing staff resources to implement all three projects. An amendment to the contract with Client Network Services Incorporated (CNSI) will be executed for the required changes to ProviderOne.

Which costs, savings, and functions are one-time? Which are ongoing? What are the budget impacts in future biennia?
Distinction between one-time and ongoing costs:

1. One-time DDI costs for the CORE Operating Rules Phase IV of $1,000,000 can be claimed at 90 percent FFP
2. One-time DDI costs for the HPID of $350,000 can be claimed at 90 percent FFP.
3. One-time DDI costs for upgrading ProviderOne to eCAMS 3.0 of $1,000,000 can be claimed at 90 percent FFP.

The HCA does not anticipate any additional significant increase in costs to the on-going operations of ProviderOne.

Budget impacts in future biennia:
None